



COOP SANTÉ FAMILIALE
FAMILY HEALTH COOP

70A Rue Lambton, Howick QC J0S 1G0
www.coopsantefamiliale.org
howickcoop@gmail.com
T 450-237-0700
F 450-237-0733

MEMBERSHIP FORM

I recognize that becoming a member and having a share in the Family Health Coop do not mean that I will automatically be assigned a family doctor. As a member, I am contributing towards maintaining local first line health services within my community.

Mandatory Shares

- To become a User Member, all physical persons must subscribe to one (1) ten-dollar (\$10) share.
- The share is to be paid only once and is reimbursable upon the end of a membership. However, we request that you opt to donate it to help us invest in medical equipment.

Annual Membership Fee

- The annual membership fee may be paid monthly by automatic debit of \$13 per month per adult member (including GST/QST and transaction fees), OR \$11 per month per business member (including GST/QST and transaction fees).
- If the membership fee is paid monthly, it will be withdrawn from your bank account at the end of each month. The monthly payment for the first month of membership must be paid at the same time as the Coop share, to become a member, by either cheque, credit card (VISA, MasterCard) or cash.
- The membership fee may be paid by cheque, credit card or cash, but the entire amount will be withdrawn in one transaction, to be repeated yearly, unless otherwise indicated by you. For this option, the total amount due is \$132.22 (including GST/QST) for regular membership, and \$114.98 (including GST/QST) for business membership.
- An employer must sign-up a minimum of two employees to benefit from the business membership rate.
- Children under 18 years of age are covered by a parent's membership.

Payment Method

Please indicate which payment method you have chosen:

Regular Membership

- \$132.22 due annually
 - Cheque
 - Visa / Mastercard
 - Cash
- \$13.00 due monthly
by pre-authorized debit*

Business Membership

- \$114.98 due annually
 - Cheque
 - Visa / Mastercard
 - Cash
- \$11.00 due monthly
by pre-authorized debit*

*Please note that the monthly payments option consists of the membership fee (broken down into 12 payments) as well as processing and transaction fees. If this option is selected, please refer to PAD consent on page 2 .

Personal Information

Last name, First name:

Date of Birth:

Medicare Card No.:

Exp. date:

Address:

Telephone:

Email:

Information on Minor Children

Last name, First name	Date of Birth	Medicare Card Number	Exp. date

Preauthorized Debit (PAD) Consent

Only complete this section if you have chosen the monthly payment option.

1. Include a specimen cheque so that we may automatically debit your membership fee at the end of each month, for a first-time member, this will be for a minimum of 12 withdrawals.
2. You may revoke this authorization at any time, by presenting a written notice, signed by you at 70A rue Lambton, Howick, Quebec, J0S 1G0 (450 237-0700). Written notice should be submitted at least 21 calendar days prior to your next PAD. You may communicate with your financial institution or consult the Payments Canada website: www.payments.ca.
3. To obtain a cancellation form or for more information on your right to cancel a PAD agreement, you may contact your financial institution or consult the Payments Canada website: www.payments.ca.
4. You have certain rights to remedy if a debit does not comply with the present agreement. For example, you have the right to be reimbursed any PAD that is not authorized or that does not comply with the terms of the present PAD agreement. For more information regarding your rights to remedy, you may contact your financial institution or consult the Payments Canada website: www.payments.ca.
5. I, undersigned, authorize the Coop de Solidarité Santé de la Famille (Family Health Coop) to make pre-authorized debits from my bank account, as identified by my specimen cheque (attached), at a fixed amount of \$_____ per month. This amount will be debited monthly from my bank account. In the case that an increase to the membership fee be decided on at the annual assembly, and the monthly debited amount be modified consequently. The first commitment is for 12 months and may be stopped at any time following this.
6. In signing this form, I waive my right to receive a written notice preceding the first pre-authorized debit.

Signature:

Date: